AFFIDAVIT OF ASSURANCE
OF PHARMACY TECHNICIAN COMPLIANCE

State of Arkansas, County of _____

I, _____, being duly sworn upon my oath state:
Print your name here.

1) I am a pharmacist duly licensed by the Arkansas State Board of Pharmacy and hold license number _____.

2) On April 1, of the current calendar year, I was pharmacist in charge at _____.
Print the name of your pharmacy here.

3) I am aware that pharmacy technician permits issued by the Board are cancelled for non-payment on April 1, if proper fees are not paid.

4) Pharmacy Technician _____ License #_____
Print the pharmacy technician's name here. Enter license #

Check one of the following:

— Is no longer employed as a pharmacy technician at this facility.

— Performed pharmacy technician duties after April 1, without a permit, at this facility.

— Is employed at this facility but did not perform pharmacy technician duties after April 1.

— Other. Explain: _____

_____

_____ (Pharmacist's Signature)

_____ (Name – Please Print)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____
Notary Public (Print, Type, or Stamp Name Of Notary)

My Commission Expires: _____

Return to: Arkansas State Board of Pharmacy, 101 East Capitol, Suite 218, Little Rock, AR 72201 (Telephone: 501-682-0190)